California Major Risk Medical Insurance Program

Visit our website at: www.mrmib.ca.gov

Major Risk Enrollment Unit
(800) 289-6574

P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

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Americans With Disabilities Act

Section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, on the basis of disability, be excluded from participating in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

California Government Code Section 11135 prohibits discrimination under a program or activity funded directly by the state or that receives financial assistance from the state on the basis of ethnic groups identification, religion, age, sex, color or disability. California Government Code Section 11136 requires state agencies, as described above, to notify a contractor of whom they have reasonable cause to believe has violated the provisions of Section 11135 or any regulation adopted to implement such section. After considering all evidence, the Executive Director of the Managed Risk Medical Insurance Board may request a hearing to take place in order to determine whether a violation has occurred.

The Americans with Disabilities Act of 1990 prohibits the Managed Risk Medical Insurance Board and its contractors from discriminating on the basis of disability, protects its applicants and enrollees with disabilities in program services, and requires the Board to make reasonable accommodations to applicants and enrollees that do not pose undue hardship on the Board.

The Managed Risk Medical Insurance Board has designated an ADA Coordinator to carry out its responsibilities under the Act. If you as a client, have any questions or concerns about ADA compliance by the Board or its contractors, you may contact the Coordinator at the following address:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695 (Voice)

Introduction

The California Major Risk Medical Insurance Program (MRMIP) is a **36 month** program developed to provide health insurance for Californians who are unable to obtain coverage in the individual insurance market. The MRMIP is administered by a five-member Board who has established a comprehensive benefit package. Services in the MRMIP will be delivered through contracts with health insurance providers. Californians qualifying for the MRMIP will participate in the payment for the cost of their coverage by paying premiums on their own behalf. The MRMIP will supplement those premiums to cover the cost of care. The MRMIP is funded annually by $40 million from tobacco tax funds.

After 36 months of enrollment in MRMIP, individuals will be disenrolled and offered guaranteed-issue coverage in the individual insurance market. All health plans with the exception of Contra Costa Health Plan will be available for guaranteed-issue coverage. Refer to page 31 for more information about guaranteed-issue coverage.

Eligibility

In order to be eligible for the MRMIP:

1. You must be a resident of the state of California. A resident is a person who is present in California with intent to remain in California except when absent for transitory or temporary purposes. However, a person who is absent from the state for a period greater than 210 consecutive days shall not be considered a resident.
2. You cannot be eligible for both **Part A** and **Part B** of Medicare, unless eligible solely because of end-stage renal disease. Provide a Medicare eligibility letter with the application as proof of end-stage renal disease. (Being eligible for one part or the other is acceptable.)
3. You cannot be eligible to purchase any health insurance for continuation of benefits under COBRA or CalCOBRA. (COBRA and CalCOBRA refer to the state and federal laws giving people under certain circumstances the right to continue coverage in an employee health plan for a limited time.) If you have COBRA or CalCOBRA you may apply for deferred enrollment.
4. You must be unable to secure adequate coverage. This can be demonstrated in any of three ways:

   • If you have been denied individual coverage within the previous 12 months. A letter/copy of a letter from a health insurance carrier, health plan or health maintenance organization denying individual coverage within the last 12 months must be submitted with your complete application.

   • If you have been involuntarily terminated from health insurance coverage within the previous 12 months for reasons other than nonpayment of premium or fraud. A letter/copy of a letter indicating involuntary termination from a health insurance carrier, health plan, health maintenance organization or employer for reasons other than nonpayment of premium or fraud must be submitted with your complete application.

   • If you have been offered, in the previous 12 months, an individual, not a group, health insurance premium in excess of your Major Risk Medical Insurance Program subscriber rate. A letter/copy of a letter must be submitted with the complete application indicating that, within the last 12 months, you have been offered by a health insurance carrier, health plan or health maintenance organization, a premium for the subscriber and/or their dependents (when applicable) in excess of the MRMIP rate for the subscriber and/or their dependents.

Note: Letters from agents/brokers indicating that an individual is unable to secure adequate private coverage will not be accepted as documentation for eligibility.

Applicants Who Know They Are Currently Not Eligible But Expect To Be in the Future

If you are not currently eligible for the MRMIP, but anticipate becoming eligible, you may also apply. Examples of this are: if you are currently enrolled in COBRA or CalCOBRA coverage or if your employer has informed you that you will be involuntarily terminated from insurance coverage sometime in the future.

To apply for a deferred enrollment, indicate when you will become eligible and include acceptable documentation. Acceptable documentation is a letter from a health insurance carrier, health plan, health maintenance organization, or employer indicating when your coverage will end. The documentation must specify the exact date of termination of current coverage. Enrollment in temporary policies does not qualify for deferred status.

If the MRMIP is not at maximum enrollment and all other eligibility criteria are met, you will be enrolled in the MRMIP on the date that eligibility will occur. If the MRMIP is at

maximum enrollment at the time you become eligible you will be placed on a waiting list. Your place on the waiting list is determined by the date on which your complete application was received, not the date that you became eligible for the MRMIP.

Applicants for deferred enrollment must submit their initial subscriber contribution with their application.

Payment will be refunded to you immediately if your deferred effective date is more than sixty (60) days from the date we receive your application.

Agents/Brokers, Employers and Applicants

Insurance Code Section 12725.5 states that it shall constitute unfair competition for an insurer, an insurance agent or broker, or administrator to refer an individual employee, or their dependent(s) to apply to the MRMIP for the purpose of separating that employee, or their dependent(s) from group health coverage provided in connection with the employee's employment.

Insurance Code Section 12725.5 further states that it shall constitute an unfair labor practice contrary to public policy for any employer to refer an individual employee or their dependent(s) to the MRMIP or to arrange for an individual employee or their dependent(s) to apply to the MRMIP for the purpose of separating that employee or their dependent(s) from group health coverage provided in connection with the employee's employment.

Medi-Cal Beneficiaries

While Medi-Cal beneficiaries are not prohibited from enrolling in the Major Risk Medical Insurance Program, a Medi-Cal beneficiary should carefully consider the cost before signing up for MRMIP coverage. MRMIP subscribers are responsible for their monthly subscriber contributions, a deductible and/or a co-payment for services which could be more than $5,000 per year. Medi-labels cannot be used for MRMIP co-payments.

How the Program Works

Choosing a Health Plan

The health plans participating in the Major Risk Medical Insurance Program provide comprehensive medical benefits for inpatient and outpatient hospital and physician services. These benefits are outlined in the health plan description pages in this handbook and are also available by calling any MRMIP health plan at their toll-free number and asking for an Evidence of Coverage or Certificate of Insurance. Subscriber contributions and the availability of each health plan appear in this handbook. **Please review all pages carefully to select a plan that is right for you.**

Benefits and Co-payments

Subscribers may choose from any plan available to them as listed in the enclosed subscriber contribution by county charts. Health Maintenance Organizations (HMOs) in MRMIP require a fixed dollar co-payment for some services and up to a 20% co-payment for other services. The Preferred Provider Organizations (PPOs) in MRMIP may also require a fixed dollar co-payment for certain services and up to a 25% co-payment for other services. The co-payment maximum per **calendar** year for all MRMIP plans is $2,500 for individuals and $4,000 for an entire household covered by the MRMIP. This maximum does not apply to services rendered by providers that do not participate in the subscriber's chosen health plan's provider network, or to services not covered by the MRMIP. There are MRMIP benefit limits of $75,000 per calendar year and $750,000 in a lifetime.

Subscriber Contributions

Subscriber contribution amounts are updated on January first of each year. In addition, your subscriber contribution may change during the year if your birthday moves you into a new age category. For married subscribers enrolled under two-party or family coverage, the age rating category will be based on the age of the applicant. Adjustments to subscriber contributions due to age changes will occur on the first of the month following the birthdate of the applicant.

Subscriber contributions may also change when a member moves from one area of the state to another. Adjustments to subscriber contributions will occur on the first of the month following notification of the move.

Each month you will receive a subscriber contribution notice from MRMIP. Subscriber contributions are payable in advance and are due the first day of every month. A subscriber contribution notice will be generated monthly, and will be sent out thirty (30) days prior to the due date.

Subscribers are responsible for their monthly subscriber contributions whether or not they receive a bill in that

month, or if the premium is paid by a third party.

A delinquency billing or final notice will be sent out on the 15th day following the paid to date.

There is a grace period of 31 days from the paid to date, and the member's coverage will remain in effect during this time.

Cancellation for nonpayment of subscriber contribution will take place on the 32nd day following the due date. The cancellation will be retroactive to the paid to date, and a cancellation letter will be generated to the subscriber. Subscribers are responsible for any services received after the disenrollment date. Subscribers who are disenrolled for nonpayment of their subscriber contributions may be reinstated upon written request only **once** in a rolling 12-month period. The subscriber must request in writing reinstatement within 60 calendar days of the date of disenrollment action and bring all delinquent payments up to date. Any further reinstatements will require a written appeal to the Managed Risk Medical Insurance Board for consideration.

A subscriber may pay either by check, money order or may elect to have their monthly subscriber contribution automatically deducted from their checking account when accepted into the MRMIP. In addition, a federally recognized California Indian tribal government can make required subscriber contributions on behalf of a member of the tribe.

Subscriber contribution checks and electronic withdrawals that are returned non-payable by the bank will result in disenrollment back to the last month paid and will result in being charged a returned item processing fee. In addition, electronic withdrawals that are returned unpaid from the subscriber's bank will result in removal from electronic withdrawal and require immediate payment by check or money order. Upon written request to reinstate, the subscriber must include a replacement check of subscriber contributions to bring the account to current status with an additional $25.00 returned item processing fee. Subscribers disenrolled due to the submission of two checks returned for insufficient funds during a rolling 12-month period will not be reinstated.

There is no application fee for applying to the MRMIP. You are required to submit your first month's subscriber contribution for MRMIP health care coverage, which is completely applied toward your first month of coverage if you are enrolled (cashing of your check does not guarantee enrollment). Qualified insurance agents and brokers may be paid a $50 fee by the state for explaining the MRMIP and assisting you in completing the application. The state does not require an individual applying to the MRMIP to pay any fee, charge or commission to a broker or agent.

Pre-Existing Condition Exclusion Period	
Blue Cross PPO **Blue Shield PPO**	For individuals enrolled in Preferred Provider Organization, there is a pre-existing condition exclusion period of 3 months. During this period, no benefits or services related to a pre-existing condition are covered. Subscriber contributions are paid during this period.

Pre-Existing Condition Exclusion Period	
Blue Cross PPO **Blue Shield PPO**	"Pre-existing condition" means any condition which during the six months immediately preceding enrollment in the MRMIP for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during that period.

Post-Enrollment Waiting Period	
Blue Shield HMO **Contra Costa Health Plan** **Kasier Permanente**	For individuals enrolled in a Health Maintenance Organization (HMO), there is a Post-Enrollment Waiting Period of 3 months. Subscribers and enrolled dependent(s), if any will not be eligible for health care services during this period. Subscribers will be informed of when this period begins and ends. No subscriber contributions are paid during this waiting period. The initial one-month subscriber contribution will be applied to the first month of service.

How You May Waive All or Part of the Exclusion/Waiting Period

The exclusion/waiting period requirement may be waived in part or all if:

1. The subscriber and enrolled dependent(s), if any, have been on the MRMIP waiting list for 180 days or longer. In this circumstance the exclusion/waiting period will be completely waived.
2. The subscriber and enrolled dependent(s), if any, have been insured by another health insurance policy (including Medicare and Medi-Cal) and application for eligibility in the MRMIP was made within 63 days following the termination of that coverage. In these circumstances you may be granted a waiver up to three months. If the coverage was less than 90 days but was at least 30 days, the subscriber and enrolled dependent(s), if any, will be given credit for either 30 or 60 days toward their MRMIP exclusion/waiting period.
3. The subscriber or enrolled dependent(s), if any, have been insured by another health insurance policy that ended because of a loss of employment, or because your employer stopped offering or sponsoring health coverage, or because your employer stopped making contributions towards health coverage and application for eligibility in the MRMIP was made within 180 days following the termination of that coverage. In these circumstances you may be granted a waiver of up to 3 months.
4. The subscriber and enrolled dependent(s), if any, were previously receiving coverage under a similar program in another state within the last 12 months. In this circumstance the exclusion/waiting period will be completely waived.

   Please submit appropriate documentation and check the appropriate boxes on the application (Questions 5 and/or 6 in the Program Eligibility Section) if you have met the criteria in #2 or #3 to waive this exclusion/waiting period.

All documentation must be received prior to or with your first month's subscriber contribution.

Dependent Coverage Information

1. Dependents may be covered under the MRMIP and are defined as a subscriber's spouse and any unmarried child who is an adopted child, a stepchild or a recognized natural child. A child ceases to be a dependent upon marriage or age 23, whichever comes first.

   A dependent also includes any unmarried child who is economically dependent upon the applicant. An unmarried child over 23 years old may be covered if that unmarried child is incapable of self-support because of physical or mental disability which occurred before the age of 23. An applicant must provide documentation in the form of doctors' records which show that the dependent child cannot work for a living because of a physical or mental disability which existed before the child became 23.

   A dependent of a subscriber can seek independent enrollment in the MRMIP if their separate program eligibility can be documented.
2. It is the responsibility of subscribers to notify the MRMIP of a request to add a dependent(s). Newborn or adopted children shall become eligible upon birth or adoption of the child. Stepchildren shall become eligible upon marriage by a subscriber to the stepchildren's parent. In all cases, the MRMIP must be notified within 30 days. All dependents are covered within 3 months of the MRMIP being notified. To add a dependent to your policy, you may request an "Add Dependent" application by calling (800) 289-6574 and talking to a MRMIP Enrollment Unit representative.
3. Enrolled dependents of a deceased subscriber or dependents of a subscriber who becomes eligible for Medicare (Parts A and B) are eligible to continue coverage in the MRMIP for as long as the enrolled dependents continue to pay subscriber contributions and meet the definition of dependent as explained in #1 above.

Waiting List

If the MRMIP reaches maximum enrollment, applicants and dependents will be placed on a waiting list. Applicants and dependents will be enrolled when spaces become available in order of the date of receipt of a complete application. Any time spent solely on the waiting list does not count toward the 3 month pre-existing condition exclusion period or post-enrollment waiting period (once enrolled) unless the person has been on the waiting list for at least 180 days. If the person has been on the waiting list 180 days or longer, the 3 month exclusion period will be waived.

Transfer of Enrollment

Subscribers and enrolled dependents may transfer from one participating health plan to another if either of the following occurs:

1. The subscriber so requests, in writing, during the program's open enrollment period which is held in

November. Subscribers will receive an open enrollment packet containing the plan choices and the new rates.

All transfers of enrollment will be effective January 1. All enrolled dependents will also be transferred to the new plan.

2. The subscriber requests a transfer in writing because the subscriber has moved and no longer resides in an area served by the health plan in which they are enrolled and there is at least one participating health plan serving the subscriber's new area.

3. The subscriber or participating health plan requests a transfer in writing because of the failure to establish a satisfactory subscriber/plan relationship and the Executive Director determines that the transfer is in the best interests of the MRMIP and there is at least one participating health plan serving the subscriber's area.

   Any transfer request must be in writing to:

Managed Risk Medical Insurance Board
Benefits Division
PO Box 2769
Sacramento, CA 95812-2769

Subscribers who transfer enrollment are not subject to pre-existing condition/waiting period exclusions.

Disenrollment

A subscriber and enrolled dependents will be disenrolled from the MRMIP when any of the following occur:

1. The subscriber and/or enrolled dependent(s) has been enrolled in MRMIP for 36 months. The disenrollment will be effective at the end of the 36th month of enrollment.

2. The subscriber so requests in writing. Disenrollment will be effective at the end of the month in which the request was received or as of the last paid date.

3. The subscriber fails to make subscriber contributions in accordance with the MRMIP's existing subscriber contribution payment and grace period practices. The effective date of disenrollment for nonpayment of a subscriber contribution will be retroactive to the last day of the month for which a subscriber contribution was paid in full.

4. The subscriber fails to meet the residency requirement or becomes eligible for Part A and B of Medicare unless eligible solely because of end-stage renal disease. Subscribers must inform the MRMIP Enrollment Unit in writing when eligible for both Part A and Part B of Medicare. Disenrollment will be effective at the end of the month in which the notification was received or as of the last paid date.

5. The subscriber or enrolled dependent has committed an act of fraud to circumvent the statutes or regulations of the MRMIP. In the event of fraud, the disenrollment could be retroactive to the original effective date.

Subscribers and dependents who have been disenrolled may not re-enroll in the MRMIP for a period of one year.

Health Plan's Dispute Resolution/Appeals

If a subscriber is dissatisfied with any action, or inaction, of the plan/provider organization in which they are enrolled, the subscriber should first attempt to resolve the dispute with the participating plan/organization according to its established policies and procedures.

Binding Arbitration

Binding arbitration is an agreement between some insurance plans and subscribers to have health care disputes reviewed by a neutral person. After reviewing all the facts and hearing both sides, the neutral person makes a decision. Both parties agree to accept the decision.

Does the plan require its members to use Binding Arbitration to resolve disputes?

Blue Cross of California: No

Blue Shield: No

Contra Costa Health Plan: No

Kaiser Permanente: Yes (includes medical and hospital malpractice)

The Managed Risk Medical Insurance Board (MRMIB) Appeals Process

The subscriber should first attempt to resolve the dispute with the participating plan according to its established policies and procedures.

This is a state program and the subscriber's rights and obligations will be determined under Part 6.5 Division 2 of the California Insurance Code and the regulation of Title 10, Chapter 5.5.

Subscribers may file an appeal with the Board over (1) any actions or failure to act which has occurred in connection with participating health plan/organization coverage, (2) determination of an applicant's or dependent's eligibility, (3) determination to disenroll a subscriber or dependent and (4) determination to deny a subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan. An appeal must be filed in writing within sixty (60) calendar days of the action or failure to act or receipt of notice of the decision being appealed to:

Managed Risk Medical Insurance Board
PO Box 2769
Sacramento, CA 95812-2769

Coverage Brochures

Health coverage brochures are available from each health plan upon request. Please see each health plan description for a phone number to call to request one.

Coordination of Benefits

Participating health plans will coordinate its coverage of benefits with any other health insurance you may have and by state law will only pay after your other insurance has paid (not including Medi-Cal and other state programs). Under the rules of the MRMIP, the benefits of this Program will not duplicate coverage you may have (whether you use it or not) under any other program or plan.

Guaranteed-Issue Coverage

After 36 months of enrollment subscribers and enrolled dependents will be disenrolled from MRMIP and may enroll into guaranteed-issue coverage that health plans will be required to offer in the individual insurance market. MRMIP will provide individuals with additional information approximately 3 months before their 36 month of enrollment.

The health plan benefit coverage will be similar to what is currently offered by the four plans participating in MRMIP, with the exception of Contra Costa Health Plan which will not be available for guaranteed-issue coverage. The guaranteed-issue coverage will provide individuals a $125,000 increase in their annual benefit limit from $75,000 to $200,000. Individuals will begin a new lifetime benefit of $750,000.

Premiums will increase 10% above what subscribers pay in MRMIP. The State and health plans will jointly subsidize the cost of the guaranteed-issue coverage.

Privacy Notification

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, please review it carefully.

When you apply for the MRMIP, the information you provide in the application is reviewed by a private contractor. The private contractor is hired by the State of California to assist in the administration of the MRMIP. The contractor uses your information to determine whether you are eligible for MRMIP. The contractor and the State will use your information for administration and evaluation of the program and for necessary purposes authorized by law.

If you are determined eligible for MRMIP, the contractor will then send your information to the health insurance plan and provider that you select, so you can begin to receive health insurance coverage under that plan. Once you are enrolled, your health plan will forward to the State information regarding the health care and services that you receive.

Uses and disclosures that are not part of the operations of the program will only be made with your written authorization. This authorization may later be revoked at your written request.

Your Rights Regarding How Your Personal Information Is Used

You have the right to request the MRMIP to restrict the use of your personal information. The Program may not agree to restrictions if it would interfere with its normal operations and administration. You also have the right to obtain a copy, or request to change the personal information you provided to the MRMIP as long as the program retains such information. You have the right to obtain an explanation of how your personal information was disclosed, other than the use of your information by MRMIP to carry out the operations of the program.

MRMIP may revise the privacy practices described here. The Program will notify its subscribers in updated program handbooks or through direct mailed notices (within 60 days) of such revision. You may complain to the MRMIP if you believe your privacy rights have been violated by contacting:

Privacy Officer
MRMIP
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

Blue Cross of California Preferred Provider Organization (PPO)
(formerly known as Prudent Buyer) **Administered by**

(800) 289-6574

Plan Highlights

No annual deductibles!

Just your co-payment up front with no paperwork for medical and prescription expenses!

Extended customer service hours for faster service.

8:30 am – 12 midnight
Monday – Friday

Blue Cross of California offers you our Preferred Provider Organization (PPO) Plan. It covers your medical and prescription expenses from your initial visit so you never have to pay a deductible. Our PPO plan offers you **more freedom than an HMO in choosing doctors, hospitals, and other medical providers**. It provides comprehensive health care coverage that is convenient and in tune with your needs, such as:

- **No annual deductible!**
- **Extensive provider network** comprising more than 40,000 PPO physicians, 29,000 HMO physicians and over 400 hospitals
- **$25 office visit** co-payment in-network
- **Prescription drug coverage** including pharmacy and mail order service–with no deductible
- **30–60% savings** when you use our in-network providers
- **No claim forms** when you use our in-network providers
- **Yearly maximum co-payment limit** in-network:
  - $2,500 per subscriber
  - $4,000 per family
- **$75,000 annual maximum** for benefits paid
- **$750,000 lifetime maximum** for benefits paid

The Blue Cross of California PPO plan includes the **Blue Cross Prescription Drug Program** with these important features:

- **No annual drug deductible!**
- **Lower cost:** Blue Cross has negotiated discounts with almost 90% of California retail pharmacies, including all of the major chain drugstores. You may choose any pharmacy, but your costs are much lower if you stay in the network.
- **Service:** Network pharmacies are supported by an on-line electronic network and will collect your co-payment when you pick up your prescription. **No claim forms to file!**
- **High value mail order program:** For many maintenance drugs, you can order up to a 60-day supply. There are no claim forms and **only a $10 co-payment** per generic prescription.

Advantages of Plan Providers

Access to one of the largest provider networks in California

The Blue Cross Preferred Provider Organization (PPO) plan gives you access to quality care through our network of physicians, hospitals and selected ambulatory surgical centers, infusion therapy, and durable medical equipment providers. Using network providers ensures maximum member savings.

Benefits are still available out-of-network

You can go outside the network and still receive benefits. You will pay a much greater share of the cost when you use a non-participating provider as you will be responsible for a larger co-payment and any charges which exceed the fee schedule.

Blue Cross contracts with most hospitals in California. However, benefits are not provided for care furnished by the few hospitals without any Blue Cross agreement except in a medical emergency.

How the Plan Works

Quality Medical Service at Discounted Rates

Blue Cross has found a way to control escalating medical expenses for subscribers. We have negotiated discounted rates with a network of physicians and hospitals across the state. These providers form the Preferred Provider Organization (PPO) plan. They give Blue Cross members a discount for care.

With no deductibles, members pay only a $25 co-payment for office visits to the in-network doctor of their choice. Blue Cross pays the rest. For most other in-network services, Blue Cross pays 75% of the discounted rate. Once you reach your maximum yearly co-payment limit, Blue Cross pays 100% of the cost for in-network covered services for the rest of the year.

Blue Cross has been helping Californians get healthy and stay healthy for over 65 years.

Important Information

If you would like more information prior to enrollment, please call **Blue Cross Customer Service** at **(800) 289-6574.**

Please note that the information presented here is only a summary. The Blue Cross Plan for MRMIP is subject to various limitations, exclusions and conditions, as fully described in the Evidence of Coverage. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.

Blue Cross of California

Benefit Summary

Type of Service	*Description of Service*	*What You Pay* *Participating Provider*	*Non-Participating Provider*
Calendar Year Deductible	There is no deductible	0	0
Co-payment	Member's amount due and payable to the provider of care	See Below	See Below
Yearly Maximum Co-Payment Limit	Member's annual maximum co-payment limit when using participating providers	$2,500 per member $4,000 per family	No yearly maximum co-payment limit for non-participating providers. You pay unlimited co-payments
	If non-participating providers are used, billed charges which exceed the customary and reasonable charges are the member's responsibility and do not apply to the yearly maximum co-payment limit		
Annual Benefit Maximum	The plan pays up to $75,000 of covered expenses per calendar year per member	You must pay for all services received after Blue Cross pays $75,000 in one calendar year for a member	
Lifetime Benefit Maximum	The plan pays up to $750,000 of covered expenses per lifetime of each member	You must pay for all services received after Blue Cross pays $750,000 in a lifetime for a member	
Hospital Services	Inpatient medical services (semi-private room); outpatient services; ambulatory surgical centers	25% of negotiated fee rate	All charges except for $380 per day for hospital services (No benefits are provided in a non-contracting hospital except in the case of a medical emergency)
Physician Office Visits	Services of a physician for medically necessary services	$25 office visit	50% of customary and reasonable charges and any in excess
Inpatient Professional Services	Services of a physician for medically necessary services	25% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Diagnostic X-Ray and Lab Services	Outpatient diagnostic x-ray and laboratory services	25% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Prescription Drugs	Maximum 30 day supply per prescription when filled at a participating pharmacy	20% for generic drug 30% for brand drug	All charges except 50% of drug limited fee schedule for generic or brand name drugs within the state of California
	60 day supply for mail order	$10 co-pay (generic) $20 co-pay (brand)	
Durable Medical Equipment and Supplies	Must be certified by a physician and required for care of an illness or injury	25% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Pregnancy and Maternity Care	Inpatient normal delivery and complications of pregnancy	25% of negotiated fee rate	All charges except for $380 per day for hospital services
	Prenatal & postnatal care	25% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Ambulance Services	Ground or air ambulance to or from a hospital for medically necessary services	25% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Emergency Care	Initial treatment of an acute serious illness or accidental injury. Includes hospital, professional and supplies	25% of negotiated fee rate	All charges except for $380 per day for hospital services except in the case of a medical emergency
	Non-emergency use of emergency room	Not covered–100% of all charges payable by member	
Mental Health Services	Inpatient nervous and mental services 10 days each calendar year except for severe mental illnesses, including serious emotional disturbances in children	25% of negotiated fee rate and all costs for stays over 10 days	All charges except for $175 per day up to 10 days. In addition, all costs for stays over 10 days
	Outpatient nervous and mental visits 15 visits each calendar year except for severe mental illnesses, including serious emotional disturbances in children	25% of negotiated fee rate for 15 visits per year. All costs for over 15 visits	50% of customary and reasonable charges and any in excess. In addition, all costs over 15 visits
Home Health Care	Home health services through a home health agency or visiting nurse association	25% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Hospice	Hospice care for members who are not expected to live for more than 12 months	25% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Skilled Nursing Facilities	Skilled nursing care	Not covered unless Blue Cross recommends as a medically appropriate more cost-effective alternative plan of treatment	
Infusion Therapy	Therapeutic use of drugs, or other substances ordered by a physician and administered by a qualified provider	25% of negotiated fee rate	You pay all charges in excess of $50 per day for all infusion therapy related administrative and professional services. You pay all charges in excess of the average wholesale price for all infusion therapy drugs and any charges in excess of the maximum per day indicated below. The combined maximum payment we will make for all Infusion Therapy services (administrative, professional and drugs) will not exceed $500 per day.
Physical/Occupational/ Speech Therapy	Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis.	25% of negotiated fee rate	You pay all charges except for $25 per visit
Chiropractic Services	No benefits	100% of all charges payable by member	

*Except for severe mental illnesses, including serious emotional disturbances in children.

With more than 60 years of health care experience and a history of financial stability, Blue Shield has earned a reputation of trust and dependability throughout California.

Access + HMO

THE SHIELD HEALTH PLANS

Blue Shield of California
An Independent Member of the Blue Shield Association

(800) 424-6521

Plan Highlights

Blue Shield's revolutionary approach to health care coverage makes it easier than ever for you to get the care you need and the service you deserve. We've added the following special features to our plan to give you greater control over your health:

- ***Access + Specialist*** gives you the option to go directly to a specialist *in the same physician group* as your Personal Physician **without** a referral for a $30 co-payment per visit. Of course, you can always choose to go through your Personal Physician and pay your standard $15 co-payment when you obtain a referral to a specialist.
- ***Access + Satisfaction*** is our member feedback program that offers to refund your standard $15 co-payment if you are ever dissatisfied with the service you receive during a covered office visit with one of our HMO network physicians.

With Access + HMO, there are virtually no claim forms to file, and your dependents (spouse and unmarried children under age 23) are also eligible for coverage under the Access + HMO Plan.

Annual maximum benefits are $75,000 per covered individual, and lifetime maximum benefits are $750,000 per covered individual.

Plan Providers

As an Access + HMO member, you have access to over 321 hospitals and 26,000 participating physicians in 33 counties. Odds are that your current doctor is a member of our HMO provider network.

You and each covered family member may choose his or her own Personal Physician from our extensive provider network. Plus, you may change Personal Physicians for any reason at any time simply by calling Blue Shield Member Services.

Blue Shield's Access + HMO Plan is available to MRMIP subscribers in the following California counties:

Alameda	San Diego
Butte	San Francisco
Contra Costa	San Joaquin
El Dorado	San Luis Obispo
Fresno	San Mateo
Kern	Santa Barbara
Kings	Santa Clara
Los Angeles	Santa Cruz
Madera	Shasta
Marin	Solano
Merced	Sonoma
Nevada	Stanislaus
Orange	Trinity
Placer	Tulare
Riverside	Ventura
Sacramento	Yolo
San Bernardino	

Please see the chart at the back of this brochure for the specific zip codes open to MRMIP.

How the Plan Works

Your Personal Physician will provide or coordinate all of your health care needs, except for Well-Woman exams and *Access + Specialist* visits. (To use the *Access + Specialist* option, your Personal Physician must belong to a physician group that has chosen to become an Access + Provider Group and offers the *Access + Specialist* option.)

To make an appointment with your Personal Physician or with a specialist in the same physician group using the *Access + Specialist* option, simply call the physician's office directly and identify yourself as an Access + HMO member. You will be asked for your Access + HMO member identification card and your co-payment at the time of your visit. (When using the *Access + Specialist* option, you will also need to show your *Access + Specialist* card.)

Always call your Personal Physician when you need medical care, unless you are using the *Access + Specialist* option. Your Personal Physician or his or her designee is available 24 hours a day, seven days a week.

Your Personal Physician or specialist will authorize any medically necessary X-ray, laboratory, emergency or hospital services. Prescription drugs can be filled at any Blue Shield participating pharmacy, including most major drugstore chains.

Co-payments

The maximum amount you pay in co-payments is $2,500 per individual and $4,000 per family in a calendar year.

Important Information

Selection of a Personal Physician from the Blue Shield HMO Physician and Hospital Directory is required when enrolling in the plan. To select a Personal Physician or for more information on Blue Shield of California and the Access + HMO Plan, call us toll-free at **(800) 424-6521**. We welcome your call.

Please note that the information presented here is only a summary of the Access + HMO Plan. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.

Blue Shield Access + HMO

Benefit Summary

Type of Service	*Description of Service*	*What You Pay*
Calendar Year Deductible	The amount that you must pay before Blue Shield assumes liability for the remaining cost of covered services	No deductible
Co-payment	Your cost of covered services	See specific service
Out-of-Pocket Maximum	The amount you are responsible for paying per calendar year	$2,500 (per covered person) $4,000 (per covered family)
Annual Benefit Maximum	The amount after which no more benefits are covered by Blue Shield during a calendar year	$75,000 (per covered person)
Lifetime Benefit Maximum	The amount after which no more benefits are covered by Blue Shield during your lifetime	$750,000 (per covered person)
Hospital Services	Physician and surgeon services, semi-private room & board, therapy, drugs	$200 co-pay per inpatient day
Physician Care	Office visits, specialist visits Allergy treatments For children (under age 18) Routine physical examinations, hearing and vision tests Immunizations	$15 co-pay per office visit Access + $30 co-pay per office visit No charge No charge
Diagnostic X-Ray and Laboratory Tests	Laboratory tests and X-rays, major diagnostic and mammography, ultraviolet light therapy	No charge
Prescription Drugs Closed Formulary	Drugs prescribed by physician and obtained at a Plan pharmacy, according to Formulary guidelines	$10 generic/$10 generic mail order $15 brand/$20 brand mail order
Durable Medical Equipment, Supplies, Prosthetic Devices and Braces	Home medical equipment, oxygen and its administration, parenteral and enteral nutrition and supplements, and home colostomy and ostomy supplies that meet the member's medical needs and are cost effective. (Routine maintenance and repair due to damage are not covered, and HMO rental charges in excess of purchase price are not covered.)	20% co-pay
Maternity Care	Prenatal & postnatal care Normal delivery Complications of pregnancy, C-section	$15 co-pay per office visit $200 co-pay per inpatient day $200 co-pay per inpatient day
Ambulance	Ground transportation as medically necessary	No charge
Emergency Care Services	Plan and non-plan emergency room visits	$25 co-pay per incident, waived if admitted (Hospitalization co-pays apply)
Mental Health Care	Mental health services Inpatient nervous and mental services 10 days each calendar year Outpatient nervous and mental services up to 15 visits per calendar year except for severe mental illnesses, including serious emotional disturbances in children	 $200 co-pay per inpatient day $15 co-pay per visit
Home Health Care/Hospice Care	Physician home visit Medically necessary visits by home health personnel Hospice care for members diagnosed as having a terminal illness with a life expectancy of 12 months or less, if it is a medically appropriate and more cost-effective plan of treatment	$25 co-pay per physician home visit per member $10 co-pay for non-physician home health personnel $10 per visit $50 per day
Skilled Nursing Services	As medically necessary in lieu of hospitalization	$50 per day
Speech/Physical/ Occupational Therapy	Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis During hospital stay	$15 co-pay per visit No charge
Other	Blood (administration of blood & blood plasma, including the cost of blood, blood plasma & blood processing)	No charge

Access + HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access + HMO specialist, and must be received while the patient is a current member. All care must be prescribed by and received from a Blue Shield Access + HMO physician or a physician to whom a Blue Shield HMO physician has referred you to for specific care. Payments for care that is not covered do not count toward your out-of-pocket maximum. Please read the Evidence of Coverage booklet for complete details of coverage.

The Blue Shield Preferred Plan

With more than 50 years of health care experience and a history of financial stability, Blue Shield has earned a reputation of trust and dependability throughout the State of California.

THE SHIELD HEALTH PLANS
Blue Shield of California
An Independent Member of the Blue Shield Association

(800) 351-2465

Plan Highlights

- Participants can access Blue Shield's impressive Preferred Provider Network (the largest network of its kind in the entire state) – over 51,000 Physician Members, more than 404 Hospitals, and 40,000 allied health care professionals.
- Through negotiated contracts with members of our Preferred Provider Network, The Blue Shield Preferred Plan offers high quality health care coverage at rates lower than traditional Blue Shield plans because all Preferred Providers have agreed to accept Blue Shield's payment allowance as payment-in-full for covered services. Plus, chances are that your current physician is a Blue Shield Preferred Member.
- Annual maximum benefits total $75,000 per covered individual, and the lifetime maximum benefits are $750,000 per covered individual.
- With Blue Shield's Preferred Plan you don't have to complete and submit any claim forms because Preferred Providers bill Blue Shield directly.
- Your dependents (spouse and unmarried children under age 23) are also eligible for coverage under Blue Shield's Preferred Plan.

Plan Providers

With Blue Shield's Preferred Plan, you can choose any physician or hospital you want. However, there is a considerable difference in your out-of-pocket costs should you decide to go to non-Preferred Providers because Blue Shield pays for covered services performed by non-Preferred Providers at a lower percentage. In addition, Blue Shield Preferred Providers have agreed to accept Blue Shield's payment allowance as payment-in-full for covered services. So, not only will your co-payments be at a higher percentage if you use non-Preferred Providers, you are also responsible for any charges that exceed Blue Shield's Allowable Amount. These additional amounts will not be applied to your maximum out-of-pocket costs.

How The Plan Works

Using Blue Shield's Preferred Plan is easy. You simply present your Blue Shield ID card to your Preferred Provider and we take care of the rest – there are no claim forms to fill out. If, however, you go to a non-Preferred Provider, you may have to complete some paperwork.

When you purchase prescription drugs, you pay the pharmacist in full, and submit the prescription drug receipt, with a claim form, to Blue Shield for processing.

Your Co-payment

When you use Preferred Providers, your maximum co-payment (the amount you're responsible for) is $2,500 per person, and $4,000 per family in a Calendar Year.

Benefits Management Program™

Blue Shield's Preferred Plan includes our Benefits Management Program – a health care cost control program that helps you identify the most appropriate and cost-effective course of treatment for which benefits may be received. Please note that failure to meet your responsibilities under the Program may result in your incurring a substantial financial liability. For this reason, we are on-hand to answer any related questions. Just call Blue Shield toll-free at (800) 343-1691.

Important Information

We Welcome Your Call

For more information on Blue Shield of California and The Blue Shield Preferred Plan simply call us toll-free at (800) 351-2465. We're here to serve you.

Please note that the information presented on these pages is only a summary of the Blue Shield Preferred Plan, and for exact terms and conditions of coverage, you should reference the Evidence of Coverage booklet.

Benefit Summary

Type of Service	*Description of Service*	*What You Pay* *Preferred Provider*	*Non-Preferred Provider*
Calendar Year Deductible	The amount that you must pay before Blue Shield assumes liability for the remaining cost of covered services	0	0
Co-payment	Your percentage of the cost of covered services	See below	See below
Out-Of-Pocket Maximum	Member's annual maximum out-of-pocket expense when using a Preferred provider.	$2,500 (per covered person)	Unlimited
		$4,000 (per family)	Unlimited
Annual Benefit Maximum	The amount after which no more benefits are paid by Blue Shield for covered services during a year	$75,000 (per covered person)	$75,000 (per covered person)
Lifetime Benefit Maximum	The amount after which no more benefits are paid by Blue Shield for covered services during your lifetime	$750,000 (per covered person)	$750,000 (per covered person)
Hospital Services	Semi-private room & board, medically necessary inpatient and outpatient services & supplies	20%	50%
Physician Care	Office and specialist visits	$25	50%
Diagnostic X-Ray Lab	Laboratory, X-Ray & major diagnostic	20%	50%
Prescription Drugs	Drugs prescribed by a physician	20% of the lesser of the cost of, or the charge made, by the majority of pharmacists in the area where the items are obtained	
Durable Medical Equipment & Supplies	Including artificial limbs, braces, oxygen, wheel chairs & hospital beds	20%	50%
Maternity	Prenatal & postnatal care Normal delivery Complication of pregnancy, including C-section	20% 20% 20%	50% 50% 50%
Ambulance	Ground transportation as medically necessary	20%	20%
Emergency Care Services	Emergency room	20%	20%
Mental Health Care	Inpatient nervous and mental services 10 days each calendar year Outpatient nervous and mental services up to 15 visits each calendar year except for severe mental illnesses, including serious emotional disturbances in children	20% 20%	50% 50%
Home Health Care/ Home Hospice Care	Medically necessary visits by physician Medically necessary visits by approved home health agency Hospice care for members diagnosed as having a terminal illness with a life expectancy of 12 months or less, if it is a medically appropriate and more cost-effective plan of treatment	20% 20%	50% 50%
Skilled Nursing Services	Semi-private accommodations (in lieu of hospital)	20%	20%
Speech/Physical/Occupational Therapy	Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis	20%	50%
	During hospital stay	No charge	
Other	Blood (administration of blood & blood plasma, including the cost of blood, blood plasma & blood processing) Facility hospice care (services of a licensed hospice – limited to six months per covered person and will only be provided when Blue Shield recommends it as a medically appropriate and more cost-effective plan of treatment).	20% 20%	50% 20%

CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Contra Costa County's own HMO, serving residents since 1974.

(877) 661-6230

Plan Highlights

Contra Costa Health Plan, founded in 1974, is stable and secure. CCHP is sponsored by the County of Contra Costa, is licensed by the California State Department of Managed Health Care, and is a federally qualified Health Maintenance Organization. Our over 50,000 members, therefore, have the assurance of knowing that CCHP must conform to the highest standards of care.

Our members appreciate

* Affordable care, plus service
* A comprehensive benefit package
* Neighborhood Health Centers with extended hours for primary and urgent care services, and access to Contra Costa Regional Medical Center
* An extensive network of community primary care and specialty physicians, and contracted community hospitals
* A 24-hour Advice Nurse service available 365 days a year
* Emergency services covered worldwide
* A Health Plan affiliation with the University of California Medical School at Davis

Plan Providers

When you select Contra Costa Health Plan (CCHP) for yourself and your family, you are gaining access to over 150 Primary Care Physicians and over 300 Specialist doctors. CCHP offers a choice of two "provider networks": One, our Health Center Network, offers primary care and access to specialty care through eleven Health Centers and at the newest hospital in the East Bay, the Contra Costa Regional Medical Center in Martinez. You would simply select the Health Center most conveniently located for you, and your doctor there will make sure you get all the preventive care, routine care, and referrals for specialty care that you need. The Regional Medical Center and local health centers are affiliated with the University of California Medical School at Davis, so you can be assured that you are getting the best medical care available.

CCHP's other "provider network" is the "Community Physician Network". With offices throughout Contra Costa County, you will easily be able to select a Primary Care Physician near you. These community physicians are affiliated with one or more of six hospitals in the area. The Contra Costa six Regional Medical Center's specialty services are also available to physicians and members of this network.

How the Plan Works

Contra Costa Health Plan (CCHP) is available to MRMIP subscribers who live in Contra Costa County.

When you join the Contra Costa Health Plan, we encourage you to call our Member Services Department. Our friendly Member Services Representatives will take as much time as you need to help with selecting your Primary Care Physician, and with any other questions you may have about how to access your plan services. You can change primary care doctors at any time, by calling Member Services and choosing another doctor from the physician network you have selected.

The 24-hour Advice Nurses are available to members every day of the year. Advice Nurses offer confidential and professional health advice, referrals to personal health education classes and counseling, and important information about prenatal care services.

All new members will receive a Member Handbook, Combined Evidence of Coverage and Disclosure document, and a Health Plan membership ID card. Call CCHP Member Services (877) 661-6230 with any questions about your membership.

Your Co-Payments and Prescription Coverage

You will be responsible for paying a co-payment for some services, such as doctor visits and hospital stays. You will be charged 20% of the cost of your prescriptions, which must be obtained at Plan-authorized pharmacies.

The maximum amount of co-payments you will pay is $2,500 per person, or $4,000 per family, in any calendar year.

Maximum Benefits

Annual maximum benefits are $75,000 per covered person, with a maximum lifetime benefit of $750,000.

Important Information

To learn more about Contra Costa Health Plan's MRMIP, call our Marketing Department at (877) 661-6230.

The information presented on this page is only a summary. For exact terms and conditions please refer to the Evidence of Coverage booklet.

Contra Costa Health Plan

Benefit Summary

Type of Service	Description of Service	What You Pay Contra Costa Health Plan Provider
Calendar Year Deductible	There is no deductible	-0-
Co-payment	Your out-of-pocket expense for the cost of authorized and covered services	Inpatient medical $200/day Inpatient psychiatric $200/day Inpatient maternity $200/day Outpatient ER $25/visit Outpatient visits $15/visit
Out-of-pocket Maximum	The annual maximum out-of-pocket expense you're responsible for (excluding unauthorized or non-covered services)	$2,500 (per covered person) $4,000 (per family)
Annual Benefit Maximum	The amount after which no more benefits are paid by Contra Costa Health Plan for authorized and covered services during a calendar year	$75,000 (per covered person)
Lifetime Benefit Maximum	The amount after which no more benefits are paid by Contra Costa Health Plan for authorized and covered services during your lifetime	$750,000 (per covered person)
Hospital Services	Semi-private room & board, and all medically necessary inpatient services and supplies including inpatient visits by physicians	$200/day
Physician Care	Medical and surgical outpatient services performed or authorized by Contra Costa Health Plan provider	Office visits $15/visit Well baby $15/visit Physical exams $15/visit
Diagnostic X-ray and Lab Tests	Inpatient and outpatient diagnostic X-ray and laboratory	-0-
Prescription Drugs	Drugs prescribed by a physician	20% of the cost of the prescription obtained at Plan-authorized pharmacies
Durable Medical Equipment & Supplies	Purchase or rental as authorized by Contra Costa Health Plan and required for care of an illness or injury	-0-
Maternity Care	Treated as any other medical condition: Inpatient Outpatient	 $200/day $15/visit
Ambulance	Ambulance service when required for an emergency or approved by a Contra Costa Health Plan physician	$15 copay
Emergency Care Services	Services in an emergency room for emergency care only – non-emergency care not covered	$25/visit
Mental Health Care	Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year Limitations do not apply to severe mental illnesses or serious emotional disturbances in children	$200/day $15/visit
Home Health Care/ Home Hospice Care	Medically necessary visits when authorized for diagnostic and treatment service and nursing care	-0-
Skilled Nursing Services	Provided only when Contra Costa Health Plan authorizes as medically necessary and more cost effective	-0-
Speech/Physical/ Occupational Therapy	Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis	$15/visit
Other	Blood and blood plasma, 24-hour Advice Nurse, member services, health education, and case management	-0-

Note: All benefits are covered by Contra Costa Health Plan only if they are prescribed or directed by a Contra Costa Health Plan physician. Other Plan limitations and exclusions apply. Please refer to the Evidence of Coverage for disclosure of Plan limitations and exclusions.
Contra Costa Health Plan is available only to residents in Contra Costa County

KAISER PERMANENTE®

Northern California

(800) 464-4000

Plan Highlights

For over 50 years, Kaiser Permanente has provided quality care for the people of Northern California. You can receive care at any of our locations in Northern California, close to work or close to home - or both.

Your family (spouse and unmarried children under age 23) are also eligible for coverage under Kaiser Permanente's MRMIP/Health Plan. Annual maximum benefits are $75,000 per covered individual, lifetime maximum benefits are $750,000 per covered individual.

There are no claim forms for the services you receive at Kaiser Permanente facilities.

Plan Providers

Representing virtually all major medical and surgical specialties, our physicians work together in one of the nation's largest medical groups to care for you and your family.

We're proud of the caliber of our physicians. Many of them graduated from the top medical schools - Harvard, Yale, Stanford, and UCLA.

You can choose your own Kaiser Permanente personal physician who will work with you to coordinate all your health care needs. Of course, you and your family are not restricted to only one of our physicians or facilities. You may receive care at any of our locations in Northern California.

Kaiser Permanente is available to MRMIP subscribers residing in areas of the following Northern California counties:

Alameda	Sacramento
Amador	San Francisco
Contra Costa	San Joaquin
El Dorado	San Mateo
Fresno	Santa Clara
Kings	Solano
Madera	Sonoma
Marin	Sutter
Mariposa	Tulare
Napa	Yolo
Placer	Yuba

Please see the chart at the back of this brochure for the specific zip codes open to MRMIP/Kaiser Health Plan enrollment.

How the Plan Works

Always carry your Kaiser Permanente MRMIP/Health Plan card. You can make an appointment by calling the appointment desk at the Kaiser Permanente facility that is most convenient for you.

Laboratories, X-ray services, and pharmacies are located at each medical facility. Urgent care is available on a same-day basis through each facility. Medical advice by phone and emergency services are available 24 hours a day.

As a group practice, our physicians can easily refer you to a specialist within your medical center, at another Kaiser Permanente facility, or to one in the community when necessary.

Co-payments

The maximum amount you pay in co-payments is $2,500 per individual and $4,000 per family in a calendar year.

Important Information

For more information about the Northern California Kaiser Permanente MRMIP/Health Plan, please call our Member Service Call Center at (800) 464-4000.

Please note that the information presented on these pages is only a summary of the Kaiser Permanente MRMIP/Health Plan for Northern California. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage booklet.

Kaiser Permanente Northern California

Benefit Summary

Type of Service	*Description of Service*	*What You Pay*
Calendar Year Deductible	The amount that you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services	No deductible
Co-payment	Your cost of covered services	See specific service
Out-of-Pocket Maximum	The amount you're responsible for paying per calendar year	$2,500 (per covered person) $4,000 (per covered family)
Annual Benefit Maximum	The amount after which no more benefits are covered by Kaiser Permanente during a calendar year	$75,000 (per covered person)
Lifetime Benefit Maximum	The amount after which no more benefits are covered by Kaiser Permanente during your lifetime	$750,000 (per covered person)
Hospital Services	Physician and surgeon services, semi-private room & board, therapy, drugs	$200 co-pay per inpatient day
Physician Care	Office visits, specialist visits Allergy treatments For children (under age 18) Routine physical examinations, hearing and vision tests Immunizations	$20 co-pay per office visit $3 co-pay per treatment $20 co-pay per office visit No charge
Diagnostic X-Ray and Laboratory Tests	Laboratory tests and X-rays, major diagnostic and mammography, ultraviolet light therapy	$5 per visit
Prescription Drugs	Drugs prescribed by physician and obtained at a Plan pharmacy, according to Formulary guidelines	$10 generic for up to a 100-day supply $35 brand for up to a 100-day supply
Durable Medical Equipment, Supplies, Prosthetic Devices and Braces	Including artificial limbs, braces, oxygen, wheel chairs & hospital beds when prescribed by a TPMG physician and obtained through Kaiser Permanente	20% of member rate No charge during hospital stay
Maternity Care	Prenatal & postnatal Care Normal delivery Complications of pregnancy, C-section	$15 co-pay per office visit $200 co-pay per day $200 co-pay per day
Ambulance	Ground transportation as medically necessary	$75
Emergency Care Services	Plan and non-plan emergency room visits	$100 co-pay per incident, waived if admitted (Hospitalization co-pays apply)
Mental Health Care	Mental health services Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year except for severe mental illnesses, including serious emotional disturbances in children	 $200 co-pay per inpatient day $20 co-pay per visit
Home Health Care/Hospice Care	Physician home visit Medically necessary visits by home health personnel Hospice care for members diagnosed as having a terminal illness with a life expectancy of 12 months or less, if it is a medically appropriate and more cost-effective plan of treatment	No charge No charge for non-physician home health personnel No charge
Skilled Nursing Services	As medically necessary in lieu of hospitalization	No charge up to 100 days per benefit period
Speech/Physical/ Occupational Therapy	Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis During hospital stay	$20 co-pay per visit No charge
Other	Blood (administration of blood & blood plasma, including the cost of blood, blood plasma & blood processing)	No charge

Note: All care must be prescribed by and received from the Permanente Medical Group (TPMG) physician, or a physician to whom a TPMG physician has referred you for specific care. Any care received outside of Kaiser Permanente Northern California Region is not covered, with the exception of emergencies.

KAISER PERMANENTE®

Southern California

(800) 464-4000

Plan Highlights

Kaiser Permanente's extensive program of managed care offers the kind of benefits you've been looking for:

Convenient Care

- You can receive care at any of our locations in Southern California, close to work or close to home - or both.
- MRMIP subscribers can get care in six Southern California counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura).

Broad-based Care

- Your family (including spouse and unmarried children under age 23) are also eligible for coverage under the MRMIP/Health Plan. Your annual maximum benefit total is $75,000 per covered individual, and the lifetime maximum benefit is $750,000 per covered individual.
- In addition to primary care visits, your MRMIP/Health Plan includes speciality care services, lab tests, X-rays and health education classes.

A Plan That's Easy to Use

- There are no claim forms or deductibles for services received at Kaiser Permanente facilities.
- When you present your Kaiser card at one of our Health Plan facilities, our computerized registration system will identify your benefits and co-payments as described on the next page.
- Upon enrollment in the MRMIP/ Kaiser Health Plan, you will receive *The Guidebook to Kaiser Permanente Services*. This publication is a directory of all Southern California facilities and services available to our members.

Plan Providers

- When you select Kaiser Permanente as your MRMIP Health Plan provider, your medical care is provided or arranged by Kaiser Permanente physicians at Kaiser Permanente medical facilities. Our dedicated physicians represent virtually all major medical and surgical specialties, and work together in one of the nation's largest medical groups to care for you and your family.
- We're proud of the caliber of our physicians. Many of them graduated from the top medical schools - Harvard, Yale, Stanford, and UCLA.
- You can choose your own Kaiser Permanente personal physician who will work with you to coordinate all your health care needs. You or your family may select a different physician at any time – your choice is never restricted to any one physician or facility.
- Emergency and urgent care are available from Kaiser Permanente 24 hours a day, 7 days a week. All necessary care, emergency or otherwise should be obtained at a Plan facility, if possible. However, in certain situations, emergency care may be obtained from non-plan providers.

How the Plan Works

- **Always carry your Kaiser Permanente MRMIP/Health Plan card** – It has important information which will assist you in making appointments and utilizing services. You can make an appointment by calling one of our convenient appointment centers.
- **Laboratories, X-ray services, and pharmacies** – These are located at each medical center (many pharmacies are open 24 hours).
- **Urgent care** is available on a walk-in basis at each facility. Medical advice by phone and emergency services are available 24 hours a day, seven days a week.
- **Referrals to specialists** – As a group practice, our physicians can easily refer you to a specialist within your service area, at another Kaiser Permanente service area, or to a non-plan specialist in the community when necessary.
- **Co-payments** – The maximum co-payments you pay in a calendar year are $2,500 per individual and/or $4,000 per family.
- **To Determine Your Rate** – Look under the Area in which you reside in the rate table. The rate is based on your age at the time you become eligible for services.

Important Information

For more information about the Southern California Kaiser Permanente MRMIP/ Health Plan program, please call our Member Service Call Center at (800) 464-4000. Please note that the information presented on these pages is only a summary of the Kaiser Permanente MRMIP/Health Plan for Southern California. For exact terms and conditions of coverage, you should refer to the Evidence of Coverage Brochure.

Kaiser Permanente Southern California

Benefit Summary

Type of Service	*Description of Service*	*What You Pay*
Calendar Year Deductible	The amount that you must pay before Kaiser Permanente assumes liability for the remaining cost of covered services	No deductible
Co-payment	Your cost of covered services	See specific service
Out-of-Pocket Maximum	The amount you're responsible for paying per calendar year	$2,500 (per covered person) $4,000 (per covered family)
Annual Benefit Maximum	The amount after which no more benefits are covered by Kaiser Permanente during a calendar year	$75,000 (per covered person)
Lifetime Benefit Maximum	The amount after which no more benefits are covered by Kaiser Permanente during your lifetime	$750,000 (per covered person)
Hospital Services	Physician and surgeon services, semi-private room & board, therapy, drugs	$200 co-pay per inpatient day
Physician Care	Office visits, specialist visits Allergy treatments For children (under age 18) Routine physical examinations, hearing and vision tests Immunizations	$20 co-pay per office visit $3 co-pay per treatment $20 co-pay per office visit No charge
Diagnostic X-Ray and Laboratory Tests	Laboratory tests and X-rays, major diagnostic and mammography, ultraviolet light therapy	$5 per visit
Prescription Drugs	Drugs prescribed by physician and obtained at a Plan pharmacy, according to Formulary guidelines	$10 generic for up to a 100-day supply $35 brand for up to a 100-day supply
Durable Medical Equipment, Supplies, Prosthetic Devices and Braces	Including artificial limbs, braces, oxygen, wheel chairs & hospital beds when prescribed by a SCPMG physician and obtained through Kaiser Permanente	20% of member rate No charge during hospital stay
Maternity Care	Prenatal & postnatal care Normal delivery Complications of pregnancy, C-section	$15 co-pay per office visit $200 co-pay per day $200 co-pay per day
Ambulance	Ground transportation as medically necessary	$75
Emergency Care Services	Plan and non-plan emergency room visits	$100 co-pay per incident, waived if admitted (Hospitalization co-pays apply)
Mental Health Care	Mental health services Inpatient visits up to 10 days per calendar year Outpatient visits up to 15 visits per calendar year except for severe mental illnesses, including serious emotional disturbances in children	 $200 co-pay per inpatient day $20 co-pay per visit
Home Health Care/Hospice Care	Physician home visit Medically necessary visits by home health personnel Hospice care for members diagnosed as having a terminal illness with a life expectancy of 12 months or less, if it is a medically appropriate and more cost-effective plan of treatment	No charge No charge for non-physician home health personnel No charge
Skilled Nursing Services	As medically necessary in lieu of hospitalization	No charge up to 100 days per benefit period
Speech/Physical/ Occupational Therapy	Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis During hospital stay	$20 co-pay per visit No charge
Other	Blood (administration of blood & blood plasma, including the cost of blood, blood plasma & blood processing)	No charege

Note: All care must be prescribed by and received from the Permanente Medical Group (SCPMG) physician, or a physician to whom a SCPMG physician has referred you for specific care. Any care received outside of Kaiser Permanente Southern California Region is not covered, with the exception of emergencies.

California Major Risk Medical Insurance Program

Area 1

Counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humbolt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba.

Rating Group	Age	BC	BS HMO[1]	BS PPO	KPNC[2]
Subscriber Only	<15	$170.00	$200.00	$182.00	$192.02
	15-29	$220.00	$200.00	$182.00	$241.92
	30-34	$280.00	$349.00	$317.00	$274.73
	35-39	$312.50	$372.00	$349.00	$294.26
	40-44	$441.25	$403.00	$442.00	$298.34
	45-49	$490.00	$441.00	$536.00	$310.45
	50-54	$633.75	$481.00	$700.00	$343.11
	55-59	$767.50	$596.00	$898.00	$425.30
	60-64	$767.50	$765.00	$1,165.00	$482.51
	65-69	$860.00	$942.00	$1,435.00	$573.79
	70-74	$905.00	$1,135.00	$1,727.00	$606.23
	>74	$958.75	$1,341.00	$2,043.00	$640.39
Subscriber & 1 Dependent	<15	$266.25	$542.00	$459.00	$444.17
	15-29	$416.25	$542.00	$459.00	$451.24
	30-34	$508.75	$681.00	$621.00	$481.81
	35-39	$560.00	$725.00	$683.00	$505.72
	40-44	$761.25	$785.00	$864.00	$508.84
	45-49	$837.50	$859.00	$1,044.00	$538.53
	50-54	$1,062.50	$940.00	$1,361.00	$598.78
	55-59	$1,270.00	$1,161.00	$1,670.00	$737.93
	60-64	$1,270.00	$1,495.00	$2,140.00	$854.01
	65-69	$1,422.50	$1,842.00	$2,637.00	$1,011.28
	70-74	$1,498.75	$2,217.00	$3,176.00	$1,069.69
	>74	$1,588.75	$2,622.00	$3,755.00	$1,134.24
Subscriber & 2 or More Dependents	<15	$400.00	$843.00	$754.00	$737.97
	15-29	$590.00	$843.00	$754.00	$749.72
	30-34	$696.25	$1,028.00	$961.00	$764.98
	35-39	$755.00	$1,109.00	$1,059.00	$820.80
	40-44	$986.25	$1,168.00	$1,241.00	$814.04
	45-49	$1,073.75	$1,209.10	$1,389.00	$834.07
	50-54	$1,331.25	$1,226.00	$1,643.00	$867.72
	55-59	$1,570.00	$1,379.00	$1,966.00	$1,004.68
	60-64	$1,570.00	$1,681.00	$2,423.00	$1,102.77
	65-69	$1,758.75	$2,071.00	$2,985.00	$1,305.35
	70-74	$1,852.50	$2,493.00	$3,593.00	$1,384.27
	>74	$1,962.50	$2,948.00	$4,249.00	$1,464.93

1 Blue Shield HMO available in the following counties:
El Dorado–95614, 95634-35, 95664, and 95762;
Kings–All zip codes;
Nevada–95712, 95924, 95945-46, 95959-60, 95975, 95977, and 95986;
Placer–95602-04, 95631, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95703, 95713, 95722, 95736, 95746-4, and 95765;
Shasta–All zip codes;
Trinity–All zip codes;
Tulare–All zip codes;
Yolo–All zip codes.

2 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Amador–95640 and 95669;
El Dorado–95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, and 95762;
Kings–93230;
Placer–95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95703, 95722, 95736, 95746-47, and 95765;
Sutter–95659, 95668, 95674, and 95676;
Tulare–93618, 93666, and 93673;
Yolo–95605, 95607, 95612, 95616-18, 95691, 95694-95, 95697-98, 95776, and 95798-99;
Yuba–95692, 95903, and 95961.

California Major Risk Medical Insurance Program

Area 2

Counties: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus.

Rating Group	Age	BC	BS HMO[3]	BS PPO	KPNC[4]
Subscriber Only	<15	$151.25	$200.00	$191.00	$183.17
	15-29	$197.50	$200.00	$191.00	$230.52
	30-34	$251.25	$349.00	$331.00	$248.08
	35-39	$280.00	$372.00	$366.00	$283.74
	40-44	$391.25	$403.00	$462.00	$289.53
	45-49	$438.75	$441.00	$560.00	$317.86
	50-54	$565.00	$481.00	$730.00	$357.21
	55-59	$687.50	$596.00	$941.00	$442.61
	60-64	$687.50	$765.00	$1,217.00	$473.16
	65-69	$770.00	$942.00	$1,501.00	$556.10
	70-74	$811.25	$1,135.00	$1,806.00	$588.93
	>74	$858.75	$1,341.00	$2,136.00	$625.02
Subscriber & 1 Dependent	<15	$237.50	$542.00	$479.00	$423.60
	15-29	$370.00	$542.00	$479.00	$429.95
	30-34	$456.25	$681.00	$648.00	$438.85
	35-39	$502.50	$725.00	$713.00	$484.74
	40-44	$675.00	$785.00	$902.00	$491.23
	45-49	$750.00	$859.00	$1,093.00	$552.68
	50-54	$947.50	$940.00	$1,423.00	$623.40
	55-59	$1,137.50	$1,161.00	$1,834.00	$774.34
	60-64	$1,137.50	$1,495.00	$2,374.00	$837.29
	65-69	$1,273.75	$1,842.00	$2,927.00	$986.23
	70-74	$1,342.50	$2,217.00	$3,522.00	$1,043.83
	>74	$1,421.25	$2,622.00	$4,166.00	$1,104.34
Subscriber & 2 or More Dependents	<15	$357.50	$843.00	$788.00	$719.20
	15-29	$526.25	$843.00	$788.00	$730.00
	30-34	$625.00	$1,028.00	$1,007.00	$759.56
	35-39	$677.50	$1,109.00	$1,106.00	$779.64
	40-44	$875.00	$1,168.00	$1,298.00	$779.34
	45-49	$961.25	$1,209.00	$1,454.00	$812.55
	50-54	$1,187.50	$1,226.00	$1,715.00	$882.20
	55-59	$1,405.00	$1,379.00	$2,057.00	$1,063.22
	60-64	$1,405.00	$1,681.00	$2,566.00	$1,087.58
	65-69	$1,573.75	$2,071.00	$3,161.00	$1,281.53
	70-74	$1,657.50	$2,493.00	$3,805.00	$1,359.02
	>74	$1,756.25	$2,948.00	$4,501.00	$1,438.25

3 Blue Shield HMO available in the following counties:
Fresno–All zip codes;
Kern–All zip codes **except** 93501-02, 93504-05, 93516, 93524, 3527-28, 93542, 93554-56, 93560, and 93596;
Madera–All zip codes;
Merced–All zip codes;
Sacramento, San Joaquin, San Luis Obispo, Solano, Sonoma and Stanislaus–All zip codes.

4 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Fresno–93242, 93602, 93606-07, 93609, 93611-13, 93616, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-22, 93724-29, 93740-41, 93744-45, 93747, 93750, 93755, 93760-62, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, and 93888;
Madera–93601, 93604, 93614, 93637-39, 93643-93645, 93653, and 93669;
Mariposa–93623;
Napa–All zip codes;
Sacramento–All zip codes;
San Joaquin–All zip codes;
Solano–All zip codes;
Sonoma–94922-23, 94927-28, 94931, 94951-55, 94972, 94975, 94999, 95401-09, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95462, 95465, 95471-73, 95476, 95486-87, and 95492.

California Major Risk Medical Insurance Program

Area 3

Counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara.

Rating Group	Age	BC	BS HMO	BS PPO	CC[5]	KPNC[6]
Subscriber Only	<15	$138.75	$241.00	$209.00	$151.25	$196.51
	15-29	$183.75	$241.00	$209.00	$151.25	$251.34
	30-34	$231.25	$416.00	$363.00	$198.75	$275.39
	35-39	$257.50	$444.00	$400.00	$198.75	$310.05
	40-44	$362.50	$481.00	$504.00	$243.75	$316.19
	45-49	$402.50	$527.00	$611.00	$243.75	$332.25
	50-54	$522.50	$576.00	$796.00	$306.25	$376.96
	55-59	$632.50	$711.00	$1,027.00	$306.25	$472.04
	60-64	$632.50	$914.00	$1,330.00	$395.00	$492.95
	65-69	$707.50	$1,127.00	$1,639.00	$512.50	$579.29
	70-74	$746.25	$1,356.00	$1,971.00	$512.50	$614.50
	>74	$790.00	$1,602.00	$2,332.00	$512.50	$649.73
Subscriber & 1 Dependent	<15	$217.50	$647.00	$522.00	$280.00	$454.50
	15-29	$345.00	$647.00	$522.00	$280.00	$461.34
	30-34	$418.75	$811.00	$708.00	$367.50	$499.04
	35-39	$460.00	$866.00	$776.00	$367.50	$535.15
	40-44	$625.00	$937.00	$984.00	$451.25	$540.84
	45-49	$686.25	$1,024.00	$1,192.00	$451.25	$580.37
	50-54	$873.75	$1,123.00	$1,555.00	$597.50	$660.52
	55-59	$1,046.25	$1,387.00	$2,000.00	$597.50	$827.15
	60-64	$1,046.25	$1,782.00	$2,591.00	$768.75	$870.80
	65-69	$1,171.25	$2,196.00	$3,191.00	$998.75	$1,025.30
	70-74	$1,233.75	$2,642.00	$3,840.00	$998.75	$1,087.09
	>74	$1,307.50	$3,126.00	$4,542.00	$998.75	$1,150.46
Subscriber & 2 or More Dependents	<15	$327.50	$1,006.00	$861.00	$475.00	$757.28
	15-29	$488.75	$1,006.00	$861.00	$475.00	$768.66
	30-34	$572.50	$1,278.00	$1,097.00	$560.00	$835.01
	35-39	$620.00	$1,323.00	$1,207.00	$560.00	$859.91
	40-44	$808.75	$1,396.00	$1,415.00	$662.50	$860.92
	45-49	$880.00	$1,442.00	$1,584.00	$662.50	$894.68
	50-54	$1,093.75	$1,461.00	$1,875.00	$786.25	$944.02
	55-59	$1,292.50	$1,645.00	$2,243.00	$786.25	$1,096.38
	60-64	$1,291.25	$2,003.00	$2,799.00	$953.75	$1,126.10
	65-69	$1,446.25	$2,468.00	$3,450.00	$1,183.75	$1,287.48
	70-74	$1,523.75	$2,972.00	$4,153.00	$1,183.75	$1,406.94
	>74	$1,615.00	$3,515.00	$4,911.00	$1,183.75	$1,490.14

5 Contra Costa Health Plan available **only** in Contra Costa County.

6 Kaiser Permanente Northern California available **only** to residents in these zip codes in these counties:
Alameda–All zip codes;
Contra Costa–All zip codes;
Marin–All zip codes;
San Francisco–All zip codes;
San Mateo–All zip codes;
Santa Clara–94022-24, 94035, 94039-43, 94085-90, 94301-10, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-32, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, and 95196.

California Major Risk Medical Insurance Program

Area 4

Counties: Orange, Santa Barbara, Ventura.

Rating Group	Age	BC	BS HMO	BS PPO	KPSC[7]
Subscriber Only	<15	$168.75	$215.00	$199.00	$161.62
	15-29	$218.75	$215.00	$199.00	$178.23
	30-34	$281.25	$372.00	$349.00	$227.96
	35-39	$313.75	$396.00	$383.00	$251.60
	40-44	$437.50	$429.00	$485.00	$262.01
	45-49	$490.00	$468.00	$588.00	$298.85
	50-54	$628.75	$513.00	$767.00	$357.48
	55-59	$768.75	$634.00	$984.00	$400.04
	60-64	$768.75	$816.00	$1,276.00	$439.27
	65-69	$861.25	$1,003.00	$1,573.00	$511.24
	70-74	$907.50	$1,209.00	$1,892.00	$541.18
	>74	$961.25	$1,429.00	$2,238.00	$574.85
Subscriber & 1 Dependent	<15	$265.00	$579.00	$502.00	$282.83
	15-29	$412.50	$579.00	$502.00	$336.85
	30-34	$510.00	$724.00	$679.00	$418.34
	35-39	$562.50	$773.00	$747.00	$459.36
	40-44	$755.00	$836.00	$947.00	$477.44
	45-49	$837.50	$914.00	$1,145.00	$541.17
	50-54	$1,053.75	$1,002.00	$1,492.00	$645.07
	55-59	$1,272.50	$1,237.00	$1,920.00	$720.07
	60-64	$1,272.50	$1,591.00	$2,486.00	$781.84
	65-69	$1,425.00	$1,961.00	$3,065.00	$913.06
	70-74	$1,501.25	$2,361.00	$3,687.00	$967.26
	>74	$1,590.00	$2,791.00	$4,361.00	$1,027.12
Subscriber & 2 or More Dependents	<15	$397.50	$899.00	$827.00	$410.53
	15-29	$585.00	$899.00	$827.00	$524.88
	30-34	$697.50	$1,095.00	$1,055.00	$616.99
	35-39	$757.50	$1,181.00	$1,159.00	$667.12
	40-44	$978.75	$1,244.00	$1,359.00	$692.86
	45-49	$1,072.50	$1,287.00	$1,524.00	$757.63
	50-54	$1,320.00	$1,304.00	$1,800.00	$854.69
	55-59	$1,571.25	$1,468.00	$2,154.00	$917.62
	60-64	$1,571.25	$1,789.00	$2,688.00	$960.51
	65-69	$1,760.00	$2,204.00	$3,310.00	$1,119.97
	70-74	$1,855.00	$2,653.00	$3,988.00	$1,187.17
	>74	$1,965.00	$3,138.00	$4,716.00	$1,263.61

7 Kaiser Permanente Southern California available **only** to residents in these zip codes in these counties:
Orange–All zip codes;
Ventura–91319-20, 91358-63, 91377, 93010-12, 93015-16, 93020-21, 93040, 93062-66, 93093, and 93099.

BC = Blue Cross
BS HMO = Blue Shield HMO
BS PPO = Blue Shield PPO
CC = Contra Costa Health Plan
KPNC = Kaiser Permanente Northern California
KPSC = Kaiser Permanente Southern California

California Major Risk Medical Insurance Program

Area 5

County: Los Angeles.

Rating Group	Age	BC	BS HMO	BS PPO[8]	KPSC[9]
Subscriber Only	<15	$178.75	$229.00	$202.00	$180.62
	15-29	$230.00	$229.00	$202.00	$196.59
	30-34	$291.25	$401.00	$351.00	$235.75
	35-39	$330.00	$429.00	$388.00	$264.22
	40-44	$461.25	$462.00	$491.00	$294.63
	45-49	$513.75	$505.00	$594.00	$336.27
	50-54	$660.00	$556.00	$560.00	$385.65
	55-59	$803.75	$685.00	$996.00	$428.15
	60-64	$803.75	$880.00	$1,293.00	$474.70
	65-69	$900.00	$1,086.00	$1,592.00	$544.81
	70-74	$948.75	$1,306.00	$1,917.00	$576.01
	>74	$1,005.00	$1,545.00	$2,268.00	$613.27
Subscriber & 1 Dependent	<15	$280.00	$623.00	$508.00	$312.43
	15-29	$433.75	$623.00	$508.00	$371.33
	30-34	$530.00	$782.00	$688.00	$433.40
	35-39	$591.25	$834.00	$757.00	$479.28
	40-44	$795.00	$903.00	$959.00	$527.42
	45-49	$878.75	$986.00	$1,158.00	$601.29
	50-54	$1,107.50	$1,083.00	$1,509.00	$694.21
	55-59	$1,331.25	$1,336.00	$1,946.00	$767.72
	60-64	$1,331.25	$1,719.00	$2,519.00	$851.39
	65-69	$1,491.25	$2,118.00	$3,103.00	$973.82
	70-74	$1,571.25	$2,548.00	$3,735.00	$1,028.06
	>74	$1,663.75	$3,014.00	$4,417.00	$1,096.21
Subscriber & 2 or More Dependents	<15	$421.25	$971.00	$836.00	$449.68
	15-29	$617.50	$971.00	$836.00	$600.68
	30-34	$726.25	$1,183.00	$1,067.00	$685.41
	35-39	$797.50	$1,275.00	$1,173.00	$738.05
	40-44	$1,031.25	$1,344.00	$1,375.00	$774.76
	45-49	$1,126.25	$1,390.00	$1,541.00	$840.72
	50-54	$1,388.75	$1,409.00	$1,821.00	$927.44
	55-59	$1,646.25	$1,585.00	$2,180.00	$992.86
	60-64	$1,646.25	$1,933.00	$2,720.00	$1,062.57
	65-69	$1,843.75	$2,381.00	$3,352.00	$1,216.80
	70-74	$1,942.50	$2,866.00	$4,035.00	$1,289.37
	>74	$2,057.50	$3,390.00	$4,772.00	$1,374.09

8 Blue Shield available to residents in all zip codes in Los Angeles County **except** 90704 (Catalina Island).

9 Kaiser Permanente Southern California available to residents in all zip codes in Los Angeles County **except** 90704 (Catalina Island).

California Major Risk Medical Insurance Program

Area 6

Counties: Riverside, San Bernardino, San Diego.

Rating Group	Age	BC	BS HMO[10]	BS PPO	KPSC[11]
Subscriber Only	<15	$148.75	$227.00	$178.00	$158.21
	15-29	$193.75	$227.00	$178.00	$163.57
	30-34	$243.75	$396.00	$309.00	$219.17
	35-39	$273.75	$421.00	$339.00	$245.63
	40-44	$381.25	$459.00	$430.00	$256.17
	45-49	$425.00	$498.00	$519.00	$291.95
	50-54	$547.50	$547.00	$679.00	$349.27
	55-59	$668.75	$676.00	$873.00	$393.82
	60-64	$668.75	$868.00	$1,130.00	$437.97
	65-69	$748.75	$1,069.00	$1,392.00	$517.37
	70-74	$788.75	$1,287.00	$1,676.00	$546.85
	>74	$836.25	$1,522.00	$1,983.00	$579.98
Subscriber & 1 Dependent	<15	$232.50	$616.00	$445.00	$306.92
	15-29	$363.75	$616.00	$445.00	$317.49
	30-34	$441.25	$771.00	$602.00	$414.71
	35-39	$491.25	$820.00	$662.00	$456.38
	40-44	$658.75	$890.00	$837.00	$468.59
	45-49	$727.50	$972.00	$1,015.00	$528.98
	50-54	$917.50	$1,063.00	$1,323.00	$629.01
	55-59	$1,107.50	$1,315.00	$1,703.00	$705.11
	60-64	$1,107.50	$1,690.00	$2,205.00	$778.81
	65-69	$1,240.00	$2,083.00	$2,716.00	$920.52
	70-74	$1,307.50	$2,507.00	$3,271.00	$973.86
	>74	$1,385.00	$2,965.00	$3,867.00	$1,036.18
Subscriber & 2 or More Dependents	<15	$348.75	$955.00	$733.00	$463.56
	15-29	$516.25	$955.00	$733.00	$566.04
	30-34	$605.00	$1,166.00	$934.00	$633.85
	35-39	$661.25	$1,255.00	$1,027.00	$671.89
	40-44	$853.75	$1,324.00	$1,204.00	$685.73
	45-49	$932.50	$1,370.00	$1,351.00	$755.02
	50-54	$1,151.25	$1,387.00	$1,592.00	$870.80
	55-59	$1,368.75	$1,562.00	$1,912.00	$941.73
	60-64	$1,368.75	$1,903.00	$2,383.00	$984.25
	65-69	$1,533.75	$2,345.00	$2,937.00	$1,165.83
	70-74	$1,615.00	$2,823.00	$3,535.00	$1,233.78
	>74	$1,711.25	$3,338.00	$4,180.00	$1,312.58

10 Blue Shield HMO available in the following counties:
Riverside–all zip codes **except** 92225-26 and 92280;
San Bernardino–all zip codes **except** 92242, 92267, 92319, and 93516;
San Diego–all zip codes **except** 91990-95, 92100.

11 Kaiser Permanente Southern California available **only** to residents in these zip codes in these counties:
San Bernardino–91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91784-86, 91798-99, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92333-37, 92339-41, 92345-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-94, 92397, 92399, 92401-08, 92410-15, 92418, 92420, 92423-24, and 92427.
San Diego–91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91990, 92007-09, 92014, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92082-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, and 92190-99.
Riverside–91752, 92220, 92223, 92313, 92320, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92599, 92860, and 92877-83.

BC = Blue Cross
BS HMO = Blue Shield HMO
BS PPO = Blue Shield PPO
KPSC = Kaiser Permanente Southern California

Checklist for Program Enrollment

Please use the following checklist to ensure better processing of your application:

- ❑ **Review** the brochure to learn about eligibility for the California Major Risk Medical Insurance Program (MRMIP) and to choose your health plan before completing the Enrollment Application.

- ❑ **Complete** the Enrollment Application on pages 27-30 of this brochure. All questions must be answered in full. If you do not provide all necessary information (including the required documentation, signatures, and payments), your application will be delayed or result in a denial.

- ❑ **Sign and date** the completed Enrollment Application on page 30.

- ❑ **Attach** the following items (your entire application may be returned to you if you do not provide the following):

  - ❑ Your **supporting documentation** that indicates your eligibility for MRMIP.
    (Page 2 of this brochure describes how eligibility can be demonstrated.)

  - ❑ A **check** for one month's subscriber contribution for your chosen health plan.
    Make check payable to **California Major Risk Medical Insurance Program**.
    (Monthly subscriber contribution rates are listed on pages 20-25 of this brochure).
    Payments that **do not equal the exact amount that is due** may delay the processing of your application.

  - ❑ **Proof of Qualifying Prior Coverage**, if applicable to you, to waive all or part of your Exclusion/Waiting Period must be received prior to or with your first month's subscriber contribution for credit to be given.
    (Please see page 5 of this brochure for more information.)

- ❑ **Insurance Agents or Brokers:** You must complete **all** boxes at the bottom of page 27 of the Enrollment Application to request reimbursement.

- ❑ **Mail** the completed Enrollment Application with your check and all necessary attachments to:

California Major Risk
Medical Insurance Program
P.O. Box 9044
Oxnard, CA 93031-9044

MRMIP Enrollment Unit
(800) 289-6574

California Major Risk Medical Insurance Program

Enrollment Application

Instructions:

Thank you for applying with California Major Risk Medical Insurance Program. Please follow these instructions to allow us to better process your application.

- Read the brochure to learn about eligibility and to choose your health plan before completing this application.
- You, the applicant/parent/legal guardian must complete this application. You are solely responsible for its accuracy and completeness.
- All questions must be answered in full. **If you do not provide all necessary information (including the required supporting documentation, signatures, and payments), your application will be delayed or result in a denial.**
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

Attach check to page 28 where indicated.
Please submit one month's subscriber contribution for your chosen health plan.
Regardless of which plan you choose, **make your check payable to California Major Risk Medical Insurance Program**.

Submit check, application and all necessary documentation to:

California Major Risk
Medical Insurance Program
P.O. Box 9044
Oxnard, CA 93031-9044

INSURANCE AGENT and Broker: If you assisted your client in completing this application, please complete this section. Complete all boxes – this will not be paid unless complete. Information missing cannot be submitted at a later date. (Please see note to Agents on page 3 of the brochure.) **Use blue or black ink only.**

Agent Name			CA Agent/Broker License No.	Tax I.D. No:/Soc. Sec. No.
Street Address			I understand that no Agent payment will be made unless and until this applicant is enrolled in the Program.	
City	State	Zip		
Phone No.	FAX No: (if available)		Signature	

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1. Check One:

☐ New Enrollment ☐ Add Dependents **Use blue or black ink only.**

2. Choice of Health Plan:

(Remember: Regardless of your choice of health plan, make check payable to California Major Risk Medical Insurance Program.)

Health Plan Name	Name of Primary Care Physician (for Blue Shield HMO only)

3. Applicant Information: Applicant must complete this section.

(If parent or legal guardian is completing this application for the applicant, please mark this box. ☐)

Last Name Applicant	First Name	M.I.	Social Security Number (optional)	Age	Birthdate Mo Day Yr	10 ☐ Male 20 ☐ Female

Check One 1 ☐ Single 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Home Phone ( )	County

Street Address (must be completed; P.O. Box not acceptable)	Suite or Unit #	City	State	Zip

Billing Name, if different

Billing Address, if different	City	State	Zip

Employer, if employed	Occupation	Business Phone ( )

Employer Street Address	City	State	Zip

4. Race/Ethnicity (Optional): Check box which best applies.

10 ☐ Aleut
11 ☐ American Indian, Native American
12 ☐ Black/African American
13 ☐ Eskimo
14 ☐ White

Hispanic
21 ☐ Cuban
22 ☐ Mexican, Mexican-American, Chicano
23 ☐ Puerto Rican
92 ☐ Other; please specify:

Asian
41 ☐ Asian Indian
42 ☐ Cambodian
43 ☐ Chinese
44 ☐ Japanese
45 ☐ Korean
46 ☐ Laotian
47 ☐ Vietnamese
94 ☐ Other; please specify:

Pacific Islander
61 ☐ Filipino
62 ☐ Guamanian
63 ☐ Samoan

Other not listed; please specify:
99 ☐

STAPLE CHECK HERE
payable to California Major Risk Medical Insurance Program

5. Family Information: List all additional family members to be enrolled.

	Last Name	First Name		M.I.	Social Security Number (optional)	Age	Birthdate Mo Day Year
30 ☐ Husband **40** ☐ Wife							
50 ☐ Son **70** ☐ Daughter			Marital Status ☐ S ☐ M				
51 ☐ Son **71** ☐ Daughter			Marital Status ☐ S ☐ M				
52 ☐ Son **72** ☐ Daughter			Marital Status ☐ S ☐ M				
53 ☐ Son **73** ☐ Daughter			Marital Status ☐ S ☐ M				
54 ☐ Son **74** ☐ Daughter			Marital Status ☐ S ☐ M				

If a dependent child is over 23 years of age, send with this application doctors records showing that the dependent child cannot work for a living because of a physical or mental disability which existed before becoming 23 years old.

Is this dependent child covered by Medicare? Yes ☐ No ☐

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6. Program Eligibility: To be eligible for the program you must answer "yes" to one of the first four questions. Provide a copy of any letter or formal written communication from a health plan documenting all "yes" answers.

	Applicant		Dependent	
	Yes	No	Yes	No
1. Within the past 12 months, have you been denied individual health insurance?	☐	☐	☐	☐
2. Within the past 12 months, have you been involuntarily terminated from health insurance coverage for reasons other than fraud or non-payment of premium?	☐	☐	☐	☐
3. Within the past 12 months, have you been offered an individual premium higher than the rate for the first choice health plan listed on this application?	☐	☐	☐	☐
4. Are you currently ineligible, but anticipate becoming eligible, and want to apply for a deferred enrollment? (See page 2.)	☐	☐	☐	☐
5. Have you and your dependent(s), if any, met the requirements to waive all or part of the exclusion/waiting period? (See page 5 under "How You May Waive All or Part of the Exclusion/Waiting Period.")	☐	☐	☐	☐
6. Within the past 12 months, were you covered in a similar high risk pool sponsored by another state before becoming a California resident?	☐	☐	☐	☐

Enroller Use Only

7. Declarations: Please read each of the following statements carefully and initial each statement. Any untrue or inaccurate responses may be reason for loss of enrollment or application of other sanctions.

	Applicant Initials	Dependent Initials
1. I declare that no individual listed on this application is eligible for **both** Part A (hospital) and Part B (professional) of Medicare. If you **are** eligible solely because of end-stage renal disease, leave blank and provide Medicare eligibility letter as proof of end-stage renal disease. (Medicare is a federal program that provides health services to older Americans and disabled persons.)		
2. I declare that all individuals listed on this application are residents of the state of California. (See page 2 under "Eligibility" for the definition of California resident.)		
3. I declare that I am not currently eligible to purchase any health insurance for continuation of benefits from my employer under the provisions of 29 U.S. Code 1161 (COBRA), or under the provisions of Insurance Code Sections 10128.50 and Health and Safety Code Sections 156.20 (Cal-COBRA). These are the laws which allow people to buy into their employer's health insurance for at least 36 months after they leave their employer. (If you **are** currently on COBRA, leave blank and refer to page 2.)		
4. I declare that all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating health plan in which the individual is enrolled. A dispute resolution process may include binding arbitration rather than a court trial to resolve any claim, including a claim for malpractice, asserted by me, my enrolled dependents, heirs, personal representatives, or someone with a relationship to us, against the participating health plan, or against the employees, partners, or agents, of the participating health plan.		
5. I declare that I have reviewed the benefits offered by the MRMIP and the subscriber contribution rates.		
6. I declare that no individual listed on this application was excluded from group health coverage solely for the purpose of being made eligible for the MRMIP.		
7. I declare that I understand and will follow the rules and regulations of the MRMIP. I understand that depositing a subscriber contribution check shall not constitute acceptance on the part of the MRMIP, or any of its subcontractors, if the application is not approved or if the member has already been disenrolled for nonpayment of subscriber contribution, fails to meet program eligibility requirements, commits program fraud, or because the dependent ceases to be a dependent, upon request by the member, or for any other reason.		

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8. Authorization and Conditions of Enrollment

Required by the Confidentiality of Medical Information Act of 1/1/80, Sect 56 et.seq of the California Civil Code for all applicants of 18 years and over. I authorize any insurance company, physician, hospital, clinic or health care provider to give Major Risk Medical Insurance Program Administrator any and all records pertaining to any medical history, services or treatment provided to anyone listed on this application for purpose of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as Administrator requires. A photocopy of this Authorization is as valid as the original.

Privacy Notification
The Information Practices Act of 1977 and the Federal Privacy Act require this Program to provide the following to individuals who are asked by the Major Risk Medical Insurance Program (established by Part 6.5 of Division 2 of the Insurance Code) to supply information: The principal purpose for requesting personal and medical information is for subscriber identification and program administration. Program regulations (Chapter 5.5 of Title 10 of the California Code of Regulations, Sections 2698.100 et.seq.) require every individual to furnish appropriate information for application to the Major Risk Medical Insurance Program. Failure to furnish this information may result in the return of the application as incomplete. The following information on the application is voluntary: social security number, race/ethnicity information and health history.

Personal information provided on this form will not be furnished to any other governmental agency.

An individual has a right of access to records containing his/her personal information that are maintained by the Major Risk Medical Insurance Program. The official responsible for maintaining the information is: Deputy Director, Eligibility, Compliance and Marketing, Managed Risk Medical Insurance Board, PO Box 2769, Sacramento, CA 95812-2769. The Board may charge a small fee to cover the cost of duplicating this information.

I understand that this is a state program and my rights and obligations under it will be determined under Part 6.5 Division 2 of the California Insurance Code and at the regulation of Title 10, Chapter 5.5.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. Page 6 has information about each plan and the arbitration requirements. You may call the plan you choose to find out more.

If this application is approved, the effective date of coverage will be determined according to applicable law and regulation and you will be informed in writing of the date. Do not drop any current coverage until you hear from us.

I understand that this contract may have waiting periods for pre-existing conditions.

I, the applicant, certify that the information provided on this application is true and correct.

X		**X**	
Signature of Applicant/Parent or Legal Guardian Required	Date	Signature of Applicant's Spouse Required (If listed on this application)	Date
X		**X**	
Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date	Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date

After filling out the application, signing and securing all necessary documentation, submit with a check for one month's subscriber contribution for your chosen health plan. **Make your check payable to California Major Risk Medical Insurance Program** and mail to:

California Major Risk
Medical Insurance Program
P.O. Box 9044
Oxnard, CA 93031-9044

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FAQ's

Answers to Frequently Asked Questions about Guaranteed-Issue Coverage

1. **What kind of restructuring will the MRMIP program have?**

   A. The MRMIP will be restructured beginning September 1, 2003 pursuant to Assembly Bill 1401, which was enacted by the California Legislature and signed by the Governor in 2002.

   The restructuring requires MRMIP subscribers and their dependents to transition out of MRMIP after 36 consecutive months of enrollment into guaranteed-issue coverage that health plans are now required to offer in the individual insurance market. The MRMIP subscriber must apply for enrollment into an individual insurance policy no later than 63 days after disenrollment from MRMIP in order to access guaranteed-issue coverage.

2. **Why are these changes being made on the MRMIP program?**

   A. MRMIP is being restructured to reduce the applicant waiting list for MRMIP and to serve more individuals with the limited funding.

3. **Will my benefits change under the guaranteed-issue plan?**

   A. The guaranteed-issue coverage benefits are similar to what the four plans participating in MRMIP currently offer, with the exception of Contra Costa Health Plan which is unavailable for guaranteed-issue coverage.

   Under the guaranteed-issue plan the annual benefit limit is increased from $75,000 to $200,000 with subscribers beginning a new lifetime benefit maximum of $750,000.

4. **Will the new plan have prescription benefits?**

   A. Yes

5. **How much will my premiums increase?**

   A. Premiums will increase 10% above MRMIP premiums. The State and health plans are jointly subsidizing the remaining cost of the guaranteed-issue coverage.

6. **How long will I be able to stay on the guaranteed–issue coverage?**

   A. Individuals who transition from MRMIP into the guaranteed-issue coverage can remain with their new individual insurance until they become eligible for Medicare, or obtain other health insurance.

7. **When will I be disenrolled from MRMIP and offered enrollment to the guaranteed-issue coverage?**

   A. If you were enrolled **before** 9/01/2000 your transition will occur **9/01/2003**. You will receive additional information approximately three months before **9/01/2003**.

   - If you enrolled in MRMIP **after** 9/01/2000 your transition will occur after being enrolled for 36 consecutive months in MRMIP. 90 days prior to the completion of your 36th month, you will receive a notice regarding the transition.

8. **Will I be able to transfer to a different insurance carrier than my present carrier at the time of my transition to guaranteed-issue coverage?**

   A. Yes, you may select any carrier that is offering the guaranteed-issue coverage.

9. **Will I be able to select insurance carriers other than the carriers offered in MRMIP program for the guaranteed-issue coverage?**

   A. Yes, you may select any carrier in the individual insurance market that is offering the guaranteed-issue coverage.

10. **How do I qualify for the guaranteed-issue coverage?**

    A. After completing 36 consecutive months of enrollment in the MRMIP program you will become eligible for the guaranteed-issue coverage. 90 days prior to transition from the MRMIP program to the guaranteed-issue coverage, you will receive notification from MRMIP.

11. **How long will I have to apply for the guaranteed-issue coverage once I have been disenrolled from the MRMIP program?**

    A. You must apply for guaranteed-issue coverage within 63 days of your termination date from the MRMIP.

    The law does not dictate pre-enrollment into the guaranteed-issue policies. The timeframes for enrollment in the guaranteed-issue policies may vary by health plan. However, the subscriber can start researching which plan would be best for them as soon as they receive their 90 day notice.

12. **If I am disenrolled from my guaranteed-issue coverage, can I re-enroll in MRMIP?**

    A. There will be a one-year waiting period for individuals who lose their guaranteed-issue coverage before they can re-apply for MRMIP.

13. **Can a subscriber transfer from one guaranteed-issue coverage to another?**

    A. Under certain circumstances a subscriber may be allowed to transfer. For example, if a subscriber moves to another area not covered by their health plan or if a health plan no longer covers the subscriber's area of residence.

14. **Do Contra Costa Health Plan members have to transition to guaranteed-issue coverage even though Contra Costa Health Plan is exempt from offering guaranteed-issue coverage?**

    A. Yes, all members regardless of their health plan must transition to guaranteed-issue coverage. Contra Costa Health Plan members will need to choose a new carrier for their guaranteed-issue coverage.